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To: Primary Home Care (PHC) Providers

Subject: Long Term Care (LTC)
Information Letter No. 03-13
Revisions to Chapter 47, Primary Home Care (PHC),
Effective September 1, 2003

Effective September 1, 2003, the Texas Department of Human Services (DHS) will adopt revisions to the provider agency rules for the Primary Home Care (PHC) program. The new rules:

- change the name of 1929(b) services (or frail elderly) to community attendant (CA) services;
- add a definition for 'Primary Home Care Program' and clarify the three types of services under the PHC program;
- remove the requirement for a provider agency nurse assessor or supervisor;
- add a definition of 'practitioner' and use this more accurate term in place of 'physician';
- remove the physician's orders from the PHC Program for primary home care and community attendant (formerly frail elderly or 1929(b) services);
- add a practitioner's statement of medical need to establish a client's need for services based on a medical diagnosis(es), and requirements regarding this medical need determination for personal care services in a non-medical program;
- change provider agency licensing requirements to only allow services in the PHC Program to be delivered under the Personal Assistance Services (PAS) category of license;
- expand the requirements for retroactive payment procedures; and
- correct several cross-references to other sections of the Texas Administrative Code.

Provider agencies will have a 30-day period to implement the new rules.

DHS has identified those provider agencies that do not currently have the PAS category of licensure for their PHC contract. These provider agencies will be contacted individually to ensure compliance with the new rule on required licensure category.

A manual revision containing the rule changes will be completed and made available in the near future.

REVISED INSTRUCTIONS

The instructions for the following forms have been revised to reflect the rule changes:

- Form 3040, Attendant Orientation/Supervisory Visit
- Form 3050-A, Health Assessment/Individual Service Plan

Provider agencies must ensure they follow the attached instructions carefully to ensure proper completion of these forms. Forms 3040 and 3050-A will be revised no later than October 1, 2003.

REVISED FORMS

The following forms have been revised to reflect the changes to the rules:

- Form 3070, DAHS/PHC Notification of Critical Omissions/Errors in Required Documentation
- Form 3070-A, Primary Home Care Notification of Critical Omissions/Errors in Required Documentation

Copies of the revised forms and the instructions are attached to this Information Letter.

The revision to Form 3070 and Instructions:

- changes the form name from 'DAHS/PHC Notification of Critical Omissions/Errors in Required Documentation' to 'Day Activity and Health Services Notice of Critical Omissions; and
- revises the purpose of the form for use only with the Day Activity and Health Services (DAHS) Program.

The revision to Form 3070-A and Instructions:

- changes the form name from 'Primary Home Care Notification of Critical Omissions/Errors in Required Documentation' to 'Primary Home Care Notice of Critical Omissions;
- adds space for the provider agency's name and vendor number;
- changes the references from R.N. supervisor to supervisor;
- replaces references to Form 3055-A with Form 3052; and
- revises the critical omissions to reflect the changes to the critical omissions effective September 1, 2003.

NEW FORMS

Form 3052, Primary Home Care Practitioner's Statement of Medical Need, is a new form. Form 3052 is used by the provider agency to obtain a statement from the client's practitioner that the client has a need for PHC services based on medical diagnosis(es). Until automation changes can occur to remove the requirements for a diagnosis code entry, provider agencies must collect the diagnosis from the practitioner.

Provider agencies should begin using the new and revised Forms for all actions processed on or after September 1, 2003. Provider agencies should continue to use the previous versions of any necessary forms for all actions already in process before September 1, 2003. Provider agencies will be allowed a 30-day grace period to print supplies of Form 3052 and use supplies of Form 3055-A. DHS staff has been instructed to accept either version of a form if it is signed between September 1, 2003 and September 30, 2003.

The new and revised forms and instructions will be available as soon as possible in the electronic version of the Community Care Provider Forms Manual (CCPFM). The CCPFM may be accessed at

<http://www.dhs.state.tx.us/handbooks/forms/default.asp?HB=CCPFM>

HIPAA REQUIREMENTS

Provider agencies are required to continue compliance with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). Please reference Long Term Care (LTC) Information Letters 02-33 and 03-05, located at <http://www.dhs.state.tx.us/programs/communitycare/index.html> for HIPPA requirements

An electronic version of this letter and the revised PHC rules can be accessed at: <http://www.dhs.state.tx.us/programs/communitycare/index.html>.

Please contact your contract manager if you have any questions. Contract managers should contact Sarah Hambrick at (512) 438-2578 if they have any questions.

Sincerely,

Signature on file

Becky Beechinor
Assistant Deputy Commissioner
Long Term Care Services

BB:ck

Attachments

Subchapter A, General Provisions and Services

- §47.1901. Definitions
- §47.1902. Required Services
- §47.1903. Staffing Requirements
- §47.1904. Training Requirements

Subchapter B, Service Requirements

- §47.2901. Referrals to Provider Agencies
- §47.2902. Assessment, Service Plan, and Requesting Prior Approval
- §47.2903. Provider Agency Requirements after Verbal Referral for Primary Home Care or Community Attendant Services
- §47.2904. Critical Omissions/Errors for Primary Home Care or Community Attendant Services
- §47.2905. Initiation of Service
- §47.2908. Monitoring Medicaid Eligibility for Primary Home Care
- §47.2909. Medical Need Determination
- §47.2910. Service Breaks
- §47.2911. Orientation of Attendants
- §47.2912. Service Plan Changes
- §47.2913. Prior Approval Renewal for Community Attendant Services
- §47.2914. Suspension of Services

Subchapter C, Claims Payment

- §47.3906. Claims Payment Reviews and Audits
- §47.3907. Missing Records
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Subchapter D, Provider Contracts

- §47.4902. Primary Home Care Provider Qualifications
- §47.4903. Provisional Contracts
- §47.4904. Current Contractors
- §47.4905. Option To Contract for Family Care Services

Subchapter E, Support Documents

- §47.5902. Reimbursement Methodology for Primary Home Care

Subchapter F, Sanctions

- §47.6902. Sanctions

Subchapter A, General Provisions and Services

§47.1901. Definitions. The following words and terms have the following meanings when used in this chapter, unless the context clearly indicates otherwise:

- (1) Abuse--Willful infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical harm, pain, or mental anguish; or willful deprivation by a caretaker or oneself of goods or services that are necessary to avoid physical harm, mental anguish, or mental illness.
- (2) Adult--A person 18 or older, or an emancipated minor.
- (3) Aged or elderly person--A person 65 or older.
- (4) Assignee--A legal entity that assumes the responsibilities and duties of a current primary home care contract through a legal assignment of contract from another legal entity.
- (5) Assignor--A legal entity that assigns its primary home care contract to another legal entity through an assignment of contract.
- (6) Attendant--A provider agency employee who provides the authorized tasks to the client.
- (7) Client--A person who is determined by the department to be eligible for services.
- (8) Community attendant (CA) services--A service under the Primary Home Care program providing in-home attendant services to eligible clients. Clients receiving CA services must have a medical need for specific tasks. CA services are provided under Title XIX of the federal Social Security Act (relating to Grants to States for Medical Assistance Programs), at 42 U.S.C. §1396t (relating to Home and community care for functionally disabled elderly individuals).
- (9) Controlling interest--an owner who is a sole proprietor, a partner owning 5.0% or more of the partnership, or a corporate stockholder owning 5.0% or more of the outstanding stock of the contracted provider, or a member of the board of directors.
- (10) Days--Any reference to days means calendar days, unless otherwise specified in the text. Calendar days include weekends and holidays.
- (11) Department--The Texas Department of Human Services.
- (12) Emancipated minor--A person under 18 years of age who has the power and capacity of an adult. This includes a minor who has had the disabilities of minority removed by a court of law or a minor who, with or without parental consent, has been married.
- (13) Exploitation--The illegal or improper act or process of a caretaker or others using an adult's resources for monetary or personal benefit, profit, or gain.
- (14) Family care (FC) services--A service under the Primary Home Care Program providing in-home attendant services to eligible adults. FC services are provided under Title XX of the federal Social Security Act (relating to Block Grants to States for Social Services), at 42 U.S.C. §1397 et seq.
- (15) Income eligible--An adult who is neither a Supplemental Security Income (SSI) or Temporary Assistance for Needy Families (TANF) client, but who has income that is equal to or less than the eligibility level established by the department.
- (16) Institution--A nursing home, personal care home, intermediate care facility for the mentally retarded (ICF-MR), or state hospital.
- (17) Medicaid eligible--An individual who is eligible for Medicaid as an SSI or TANF client, or who is eligible for medical assistance only while living in the community.
- (18) Neglect--Failure to provide for oneself the goods or services that are necessary to avoid physical harm, mental anguish, or mental illness; or the failure of a caretaker to provide these goods or services.
- (19) Person with a disability--A person who, because of physical, mental, or developmental impairment, is limited in his capacity to adequately perform one or more essential activities of daily living. Activities of daily living include but are not limited to:
 - (A) personal and health care;

- (B) mobility;
- (C) communication; and
- (D) money management.

(20) Practitioner--A physician currently licensed in Texas, Louisiana, Arkansas, Oklahoma, or New Mexico; a physician assistant currently licensed in Texas; or a registered nurse approved by the Texas State Board of Nurse Examiners to practice as an advanced practice nurse.

(21) Practitioner's statement--A document signed by a practitioner that includes a client's diagnosis, current medications, and a statement that the client has a current medical need for assistance with personal care tasks and other activities of daily living.

(22) Primary Home Care Program--A Texas Department of Human Services attendant care services program. Community attendant (CA), primary home care (PHC), and family care (FC) are the three types of services available under the Primary Home Care Program.

(23) Primary home care (PHC) services--A service under the Primary Home Care Program providing in-home attendant services to eligible clients. Clients receiving PHC services must have a medical need for specific tasks. PHC services are provided under Title XIX of the federal Social Security Act, at 42 U.S.C. §1396a et seq. (relating to State plans for medical assistance).

(24) Prior approval--A decision made by the department regional nurse/caseworker, before services begin and before payment can be made, that the applicant or client meets the department criteria for the requested service.

(25) Provider agency--A home and community support services agency that has a contract with the department to provide services under the Primary Home Care Program.

(26) Provisional contract--A time-limited contract.

(27) Special attendant--A provider agency employee who can substitute for another attendant.

(28) Supervisor--A provider agency employee who:

- (A) coordinates the delivery of services in the client's service plan;
- (B) supervises attendants; and
- (C) complies with §97.404 of this title (relating to Standards Specific to Agencies Licensed to Provide Personal Assistance Services).

(29) Unit of service--One hour of authorized service delivered to a prior-approved client.

§47.1902. Required Services. A provider agency must provide services that include but are not limited to:

(1) Personal care. These services include assistance with activities related to the care of the client's physical health. These activities include:

- (A) bathing;
- (B) dressing;
- (C) preparing meals;
- (D) feeding;
- (E) exercising;
- (F) grooming;
- (G) caring for routine hair and skin needs;
- (H) taking self-administered medication;
- (I) toileting; and
- (J) transferring/ambulating.

(2) Home management. These services include assistance with housekeeping activities that support the client's health and safety. These activities include:

- (A) changing bed linens;
- (B) housecleaning;
- (C) laundering;

- (D) shopping;
- (E) storing purchased items; and
- (F) washing dishes;

(3) Escort. Accompanying the client on trips to obtain medical diagnosis or treatment or both. This service does not include the direct transportation of the client by the attendant.

§47.1903. Staffing Requirements.

(a) A supervisor must supervise attendants. The provider agency must not knowingly send attendants who have symptoms of communicable disease to a client's home.

(b) Attendants must:

- (1) be at least 18;
- (2) be neither legal nor foster parents of minor children who receive the service; and
- (3) not be spouses of clients (not applicable to family care).

(c) The two types of attendants are as follows:

(1) Regular attendants. Each regular attendant must receive a general orientation as described in §47.2911 of this chapter (relating to Orientation of Attendants), before or at the time services begin.

(2) Special attendants. Special attendants may be used to initiate services, prevent a break in service, or provide ongoing services. Although special attendants are required to receive the general orientation specified in paragraph (1) of this subsection, they do not have to receive it in the client's home as long as they meet the following requirements.

(A) The special attendant must meet the requirements in subsection (b) of this section.

(B) The special attendant must either:

(i) meet the requirements described in §97.701 of this title (relating to Home Health Aides); or

(ii) meet the following requirements:

(I) have six continuous months of experience in delivering personal care tasks in family care or primary home care; and

(II) have demonstrated competency in providing personal care tasks to the satisfaction of the supervisor.

§47.1904. Training Requirements. Before assuming responsibilities, all supervisors must receive training in the policies and procedures of the Primary Home Care Program, and family care services, if the provider agency delivers this service.

Subchapter B, Service Requirements

§47.2901. Referrals to Provider Agencies.

(a) Unless a client needs a verbal referral for services, provider agencies receive written referrals based on the following priorities:

- (1) client's choice; and
- (2) rotation of eligible providers.

(b) The client's or provider agency's choice of attendants is not limited unless:

- (1) the caseworker has specified that a particular attendant should not be employed by the provider agency; or
- (2) the supervisor, caseworker, or regional nurse has determined that the attendant is not providing adequate care.

(c) The provider agency must refer an individual who is eligible for Medicaid or who is potentially eligible for Medicaid to the Texas Department of Human Services within seven days of the date the provider agency develops the client's service plan.

§47.2902. Assessment, Service Plan, and Requesting Prior Approval.

(a) Provider agencies must obtain, from the regional nurse, prior approval of medical need for applicants and renewal of prior approval for certain clients.

(1) Except as indicated in paragraph (2) of this subsection, only initial prior approval of medical need by the department regional nurse is required for applicants who have a medical condition causing functional impairment in personal care.

(2) Annual renewal of prior approval by the department regional nurse is required for clients who are eligible under the provisions of the Social Security Act, §1929(b).

(b) When a provider agency receives a referral from a caseworker, the supervisor must make every effort to request prior approval for the client within 14 days of the authorization for community care services referral date.

(c) If the provider agency cannot request prior approval within 14 days, the provider agency must notify the caseworker about the reason for delay. This notification must be sent on the case information form within 14 days of the referral date.

(d) The supervisor must conduct an initial on-site assessment for all referrals using the client assessment form.

(e) If the supervisor cannot conduct the assessment within 14 days of the referral date, the provider agency must notify the caseworker about the reason for delay. The notification must be sent on the case information form, within the 14-day period.

(f) Using the service plan form, the supervisor must develop a service plan for the client. The service plan must be agreed upon and signed by the client/client's family and agency. The service plan must include:

- (1) the client assessment;
- (2) tasks and hours;
- (3) the attendant service schedule; and
- (4) frequency of supervisory visits.

(g) After the supervisor conducts the assessment, he must obtain the practitioner's statement described in §47.2909 of this chapter (relating to Medical Need Determination). If the provider agency cannot obtain the practitioner's statement within 14 days of the referral date, the provider agency must notify the caseworker about the reason for delay by sending the case information form within the 14-day period. The case information form must include the date of the assessment and must be dated after the assessment date.

§47.2903. Provider Agency Requirements after Verbal Referral for Primary Home Care or

Community Attendant Services.

(a) When a provider agency is contacted by a caseworker about the need for verbal prior approval, the supervisor must make an on-site assessment of the applicant and must contact the applicant's practitioner to get the verbal or written practitioner's statement.

(b) The supervisor must verbally request prior approval and give the regional nurse:

(1) a summary of the service plan, including:

(A) a description of the applicant's medical need for personal care tasks;

(B) results of the assessment; and

(C) medical diagnosis(es);

(2) the date of the verbal or written practitioner's statement;

(3) social assessment information and service plan recommendation developed by the caseworker; and

(4) other information the regional nurse may require.

(c) The supervisor documents in the client's case folder the date and time of the verbal approval and the name of the regional nurse who gave the approval.

(d) The provider agency must send prior approval forms for verbally approved services to the regional nurse in time for them to be:

(1) postmarked within 30 days of the date of verbal prior approval;

(2) stamped, in the absence of a legible postmark, as received by the department no later than 35 days of the date of verbal prior approval; or

(3) if hand-delivered, stamped as received by the department no later than 30 days of the date of the verbal prior approval.

(f) If the provider agency submits documentation that fails to support the verbal prior approval, the provider agency must submit any additional information the regional nurse requests. This additional information must be postmarked within seven days of the date of request, unless the regional nurse gives written permission for an extension.

If the provider agency fails to submit prior approval forms or additional documentation within the required time frames, or if the additional documentation is not adequate, the regional nurse cancels the verbal prior approval.

§47.2904. Critical Omissions/Errors for Primary Home Care or Community Attendant Services.

(a) If the client assessment/service plan form or the practitioner's statement is missing, or if any of the following critical omissions or errors has occurred in the required documentation, the provider agency cannot obtain prior approval.

(1) The supervisor fails to sign or date the client assessment/service plan.

(2) The practitioner's statement does not include the credential of the practitioner who signed the order.

(3) Service plan tasks are not identified on the service plan form.

(4) The total number of service hours per week is not specified on the service plan form.

(5) The practitioner's statement does not include the license number of the practitioner who signed it.

(6) The practitioner who signed the order is excluded from participation in Medicare or Medicaid.

(7) The practitioner's signature is not on the practitioner's statement.

(8) The practitioner's signature date is missing or illegible and the provider agency's stamped date is missing from the practitioner's statement.

(9) The provider agency's stamped date used instead of the practitioner's date on the practitioner's statement does not include the provider agency's name, abbreviated name, or initials.

(b) Corrections of critical omissions or errors in provider agency documentation must be

postmarked or date stamped as received by the department within 14 days after the regional nurse mails notification of the omission or error to the provider agency. If the provider agency fails to meet this time frame, the date of prior approval can be no earlier than the postmark or department-stamped date on the corrected documentation, or the department may refer the client to another provider agency of the client's choice.

§47.2905. Initiation of Service.

- (a) The provider agency must initiate services within the following time frames:
 - (1) for primary home care, within seven days of the beginning date of coverage on the authorization for community care services; and
 - (2) for family care, within 14 days of the date on the authorization for community care services.
- (b) The provider agency must provide services to the client according to the client's individual service plan.
- (c) The attendant must document on the service delivery record that services are provided to the client.
- (d) If the provider agency does not initiate services within the seven-day period, the provider agency must notify the caseworker, using the case information form, by the eighth day after the beginning date of coverage on the authorization for community care services. The notification must include the reasons for the delay and the date services are scheduled to begin.
- (e) The provider agency must complete and return the authorization for community care services to the caseworker within 14 days from the beginning date of coverage on the authorization for community care services. The provider agency must indicate the date services were initiated, the schedule for delivering services, the total hours authorized for the client, and the name of the attendant.
- (f) For verbally negotiated referrals, the provider agency must begin services:
 - (1) on the date verbally negotiated with the caseworker, if the regional nurse gives prior approval;
 - (2) on the date of the regional nurse's verbal approval, if that date is after the negotiated date; or
 - (3) for family care, on the date verbally negotiated with the caseworker.

§47.2908. Monitoring Medicaid Eligibility for Primary Home Care. Each month the provider agency must verify that a client has received a current medical care identification card. If the client becomes ineligible for Medicaid, the provider agency must suspend services and notify the caseworker or staff in the caseworker's office on the day of the suspension or the next Texas Department of Human Services workday.

§47.2909. Medical Need Determination.

- (a) Applicability. This section does not apply to family care.
- (b) Obtaining medical need. The provider agency must obtain the statement of medical need from the practitioner and submit the statement to the regional nurse within the time frame described in §47.2902 of this chapter (relating to Assessment, Service Plan, and Requesting Prior Approval) for:
 - (1) applicants who are referred to the provider agency (unless the applicant requests and is to receive family care only);
 - (2) clients who are receiving family care only and who are referred to the provider agency for primary home care or community attendant services; and
 - (3) clients who are referred to the provider agency to have medical need re-assessed, as requested by the case manager, such as when the initial medical need was established for a

limited time.

(c) Negotiated referrals. In the case of negotiated referrals, the provider agency:

(1) must initially determine medical need by obtaining an oral statement of medical need from the practitioner before initiating services as described in §47.2905 of this chapter (relating to Initiation of Service); and

(2) must then complete and submit a practitioner's statement as described in §47.2903 of this chapter (relating to Provider Agency Requirements after Verbal Referral for Primary Home Care or Community Attendant Services).

(d) Mental illness and mental retardation. Persons diagnosed with mental illness or mental retardation or both are not considered to have established medical need based solely on such diagnoses, but may establish medical need through a related diagnosis.

(e) Documentation of medical need determination. The provider agency must maintain the practitioner's statement in the client file.

§47.2910. Service Breaks.

(a) The provider agency must ensure that a client is not without services for more than 14 consecutive days after service initiation, unless:

(1) the provider agency obtains written approval from the caseworker; or

(2) the service break is caused by circumstances described in §47.2914 of this title (relating to Suspension of Services).

(b) Verbal approval for a service break extension beyond 14 days must be obtained from the caseworker before obtaining written approval. The provider agency must request written approval by submitting a case information form to the caseworker within seven days of the date verbal approval was given. Subsequent approval(s) for service break(s) are not needed if the initial break(s) extend another 15 days or more. Regardless of how long the service break lasts, it is considered only one service break if the break is consecutive.

(c) The provider agency must ensure that a Priority 1 client is not without authorized/scheduled services after service initiation unless:

(1) the service break is caused by circumstances described in §47.2914(a) and (b) of this title (relating to Suspension of Services); or

(2) the client is not at home when the attendant is scheduled to provide services; or

(3) the client requests that services not be provided on a specific day(s); or

(4) the client agrees to less than scheduled hours as documented in the record; and

(5) the provider agency notified the caseworker on the case information form (or facsimile) of the reason within seven days of the break.

(d) The provider agency must notify the caseworker within 7 days of the service break by using the department's case information form. The form must include the reason for the service break.

§47.2911. Orientation of Attendants.

(a) The supervisor must orient the attendant before or when services for the client begin. The supervisor must meet with the attendant and the client at the client's home to give the attendant a general orientation about the client. The purpose of the orientation is to:

(1) provide the attendant with information needed to provide the authorized services;

(2) ensure that the attendant is able to recognize and report any changes in the client's condition; and

(3) ensure that the attendant is competent to provide authorized tasks.

(b) The supervisor is not required to give this onsite orientation to the special (substitute) attendant, but must give the special attendant verbal or written orientation before the special attendant goes to the client's home.

§47.2912. Service Plan Changes.

(a) No later than the first Texas Department of Human Services (DHS) workday after becoming aware of the change, the provider agency must verbally notify the caseworker or staff in the caseworker's office about any change that may require an increase in hours or service termination. The provider agency must follow up this verbal notification with further notification in writing, to the caseworker, using the attendant orientation/supervisory visit form. Written notification must occur within seven days after verbal notification.

(b) When a caseworker initiates an increase or decrease in hours or service termination, he sends the authorization for community care services to the provider agency to:

(1) authorize the change if the client receives family care or primary home care services; and

(2) notify the provider agency to request authorization of the change from DHS's regional nurse when the change is for a client who receives community attendant services. To request approval of the change, the provider agency must forward to DHS's regional nurse the authorization for community care services and the attendant orientation/supervisory visit form within seven days of the receipt of the authorization for community care services from the caseworker.

(c) The provider agency must implement an increase in hours on the beginning date of coverage indicated on the authorization for community care services.

(d) If the caseworker notifies the supervisor that an immediate change is needed, the supervisor and the caseworker discuss:

- (1) the increase in hours;
- (2) the reason(s) for the immediate change; and
- (3) the effective date of the change.

(e) The supervisor must send the attendant orientation/supervisory visit form to the caseworker within 30 days of receiving verbal approval for a client needing an immediate increase in hours. The form must include the following documentation:

- (1) the effective date of the verbal approval of the increase in hours;
- (2) the increase in hours; and
- (3) the name of the caseworker giving verbal approval.

§47.2913. Prior Approval Renewal for Community Attendant Services.

(a) For clients who receive community attendant services, the supervisor must send the following forms to the regional nurse to obtain renewal of prior approval:

- (1) summary of client need for service, if provided;
- (2) authorization for community care services; and
- (3) attendant orientation/supervisory visit.

(b) The supervisor must submit the prior approval material to the regional nurse within 14 days of the referral date.

§47.2914. Suspension of Services.

(a) The provider agency must suspend services before the end of the prior approval period if one or more of the following circumstances occurs.

(1) The client leaves the state or moves to a county in which the provider agency does not provide primary home care.

(2) The client dies.

(3) The client is admitted to an institution or a hospital.

(4) The client requests that services or tasks end.

(5) The department denies the client's Medicaid eligibility (not applicable to family care).

(6) The client or someone in the client's home threatens the health or safety of the attendant or his supervisor.

(7) The department enforces sanctions against the provider agency by terminating the contract.

(b) The provider agency may suspend services if one or more of the following circumstances occurs.

(1) The client or someone in the client's home racially discriminates against the attendant or the supervisor in the client's home.

(2) The client or someone in the client's home sexually harasses the attendant in the client's home.

(c) No later than the first DHS workday after services are suspended, the provider agency must verbally notify the caseworker or staff in the caseworker's office about the reason the provider agency suspended services. Written notification, on the case information form, must be sent to the caseworker within seven days of service suspension.

Subchapter C, Claims Payment

§47.3906. Claims Payment Reviews and Audits.

(a) Service delivery records. The provider agency must use the Texas Department of Human Services' (DHS's) service delivery record form or replica unless it obtains written approval from DHS to use a form which deviates in format and/or in information from DHS's service delivery record form. The provider agency must not preprint or pre-enter the time in, time out, total time, or monthly total of hours in the record of time portion of any timesheet.

(b) Timekeeper(s). The provider agency must designate a timekeeper(s) to verify that the hours recorded on the timesheet were worked and that the tasks assigned were completed. The timekeeper may be the supervisor.

(c) Timesheet entries by the attendant. The attendant must enter the daily total time and/or the time in, time out, and monthly total of hours. An attendant who is unable to complete and sign the timesheet may designate a neighbor, friend, or relative to complete and sign the timesheet. The provider agency must document in writing the reason the attendant is unable to complete and sign the timesheet and must document in writing who is authorized to make these entries.

(d) Corrections to the record of time. The attendant and/or the timekeeper may correct an entry(ies) to the time in, time out, daily total time, or monthly total of hours without initialing the correction if the correction does not increase the daily total time or monthly total of hours.

(e) Failure to maintain records. If the provider agency fails to maintain records as specified in §69.205 of this title (relating to Contractor's Records), the department may initiate corrective action plans and/or monetary exceptions.

(f) Documentation errors. Documentation errors, both administrative and financial, may cause claims for services to be disallowed and may cause monetary exceptions. For primary home care services, an exception of 12% of the paid unit rate is the administrative portion applied to the unit of service.

(g) List of administrative errors. Administrative errors include, but are not limited to, the following.

(1) The provider agency leaves the month and year of service blank at the top of the timesheet, but the month and year can be verified elsewhere on the timesheet. The department applies the error to the total number of units reimbursed for the pay period.

(2) The attendant completes the time in and time out columns, but leaves the daily total time column blank, and the timekeeper fails to enter the daily total time based on the attendant's entry. The department applies the error to the total number of units reimbursed for the days left blank.

(3) The timekeeper fails to enter a date of signature to certify the total number of hours the attendant worked. The department applies the error to the total number of units reimbursed for the pay period.

(4) The timekeeper corrects the date of signature, but fails to initial the correction. The department applies the error to the number of units reimbursed after the earliest signature date.

(5) The timekeeper enters an illegible date of signature or makes an illegible correction to the date. The department applies the error to the total number of units reimbursed for the pay period.

(6) The timekeeper enters a date of signature that is before the date of the last day services are delivered. The department applies the error to the total number of units reimbursed after the signature date.

(7) The timekeeper fails to sign the timesheet. The department applies the error to the total number of units reimbursed for the pay period.

(8) The timekeeper uses a signature stamp, but fails to initial the stamped signature. The department applies the error to the total number of units reimbursed for the pay period.

(9) The attendant and/or timekeeper uses liquid paper/correction fluid to correct an entry in the record of time, signature, or date portion of the timesheet. The department applies the error to the total number of units reimbursed for the pay period if the correction is for the signature, date, or record of time for the total number of hours in the pay period. If the correction is for the record of time for a particular day, the department applies the error to the number of units reimbursed for each day corrected with the liquid paper/correction fluid.

(10) The attendant and/or timekeeper makes an illegible entry in or an illegible correction to any portion of the record of time column. The department applies the error to the total number of units reimbursed for the days in which entries are illegible.

(11) The attendant fails to initial an increase in the daily total time or the monthly total of hours for the pay period. The department applies the error to the number of units reimbursed in excess of the original entry.

(12) The attendant fails to sign the timesheet. The department applies the error to the total number of units reimbursed for the pay period.

(13) The department reimburses the provider agency for services, but a valid prior approval/confirmation of services form is missing for the period reimbursed by the agency. The department applies the error to the total number of units reimbursed and not covered by a valid prior approval/confirmation of services form.

(h) List of financial errors. In the absence of acceptable secondary documentation, financial errors include, but are not limited to, the following.

(1) The department reimburses the provider agency for services, but the timesheet is missing for the period for which services are reimbursed. The department applies the error to the total number of units reimbursed for the pay period.

(2) The attendant leaves the entire record of time column blank. The department applies the error to the total number of units reimbursed for the pay period.

(3) The department reimburses the provider agency for hours that exceed the total number of hours recorded on the timesheet. The department applies the error to the total number of units reimbursed in excess of the units recorded on the timesheet. If the sum of the time in and time out does not equal the total time or if the sum of the daily totals of time does not equal the monthly total of hours on the timesheet, then the lesser of the two totals is used to calculate the total number of hours recorded on the timesheet.

(4) The department reimburses the provider agency for units of service for days on which the client did not receive services or was Medicaid ineligible (not applicable to family care). The department applies the error to the total number of units reimbursed for the day on which the client did not receive services or was Medicaid ineligible (not applicable to family care).

(5) The provider agency makes a claim for services, but a valid practitioner's statement is missing. The department applies the error to the total number of units claimed and not covered by a valid practitioner's statement.

(i) Reimbursement for underpayments. The department reimburses the provider agency for any underpayments reflected in the audit reports. The department may withhold the reimbursement of an underpayment if the provider agency has an outstanding audit exception.

§47.3907. Missing Records. The provider agency may request from the department copies of missing service records. The provider agency must reimburse the department for the actual cost of reproduction, including the actual cost of staff time and equipment use and a minimal cost for each page reproduced. The provider agency must submit a written request to the contract manager for copies of records. This service does not remove the provider agency's contractual obligation to maintain records.

§47.3908. Retroactive Payment Procedures

(a) Applicability.

(1) This section does not apply to family care.

(2) A provider agency that chooses to request retroactive payment must comply with the requirements of this section.

(b) Definition of retroactive payment. A retroactive payment is payment by the Texas Department of Human Services (DHS) to a provider agency for services under the Primary Home Care Program that are provided before the date the case manager determines the person's eligibility for the services.

(c) Reimbursement.

(1) The provider agency may be reimbursed for services provided before the date a completed, signed, and dated copy of DHS's Application for Assistance--Aged and Disabled form is received:

(A) for up to three months for a person who does not have Medicaid eligibility at the time of the request for retroactive payment; and

(B) for an indefinite period for a person who is Medicaid eligible at the time of the request for retroactive payment.

(2) DHS will only reimburse the provider agency for the:

(A) services described in §47.1902 of this chapter (relating to Required Services);

(B) number of hours of services allowed to be provided the person, calculated as described in §48.2918 of this title (relating to Eligibility for Primary Home Care); and

(C) allowable costs of the Primary Home Care Program, as described in 1 TAC, Chapter 355 (relating to Medicaid Reimbursement Rates).

(3) DHS will not reimburse the provider agency if:

(A) the provider agency fails to submit the required documentation within the required time frames; or

(B) the person provided services does not meet the requirements described in subsection (d) of this section.

(d) Requirements before requesting retroactive payment. The provider agency may not request retroactive payment unless:

(1) the person appears to be Medicaid eligible as defined in §48.1201 of this title (relating to Definition of Program Terms);

(2) the provider agency obtains the practitioner's statement and establishes medical need under §47.2909 of this chapter (relating to Medical Need Determination);

(3) the person requires at least one personal care service as described in §47.1902 of this chapter; and

(4) the provider agency has verified and documented that the person is not already receiving services under the Primary Home Care Program from another provider agency.

(e) Service plan. The provider agency must develop a service plan for the person as described in §47.2902 of this chapter (relating to Assessment, Service Plan, and Requesting Prior Approval).

(f) Intake referral. On the day that the provider agency develops a service plan for the person, the provider agency must contact the local DHS office by telephone and make an intake referral by providing DHS information on the person to start the eligibility process.

(g) Service initiation. The provider agency must begin to provide services to the person on the date the provider agency develops the service plan and processes the intake referral as described in subsections (e) and (f) of this section.

(h) Requesting retroactive payment.

(1) A provider agency's written request for retroactive payment must include:

(A) a copy of the service plan required by subsection (e) of this section; and

(B) the retroactive payment information, including the:

- (i) name of the provider agency;
 - (ii) contact information for the person;
 - (iii) date services were started;
 - (iv) tasks provided to the person. This includes both tasks allowed and not allowed by the Primary Home Care Program;
 - (v) weekly hours of service provided to the person. This includes hours allotted to tasks allowed and not allowed by the Primary Home Care Program; and
 - (vi) cost per hour of service charged to the person.
- (2) The provider agency must submit the written request for retroactive payment:
 - (A) to the case manager or, if no case manager has been assigned, to DHS intake staff; and
 - (B) within seven days after the date the provider agency processes the intake referral.
- (i) Charges to persons provided services.
 - (1) The provider agency may charge a person for services for which the provider agency intends to request retroactive payment, unless the person is Medicaid eligible.
 - (2) The provider agency must reimburse the entire amount of all payments made by the person to the provider agency for eligible services, even if those payments exceed the amount DHS will reimburse for the services, if DHS determines that the person is eligible for the Primary Home Care Program.
- (j) Documentation of retroactive payment requests. The provider agency must maintain documentation of retroactive payment requests in the client file.

Subchapter D, Provider Contracts

§47.4902. Primary Home Care Provider Qualifications.

(a) To qualify as a home and community support services (HCSS) agency under contract with the Texas Department of Human Services (DHS) to provide services under the Primary Home Care Program, an HCSS agency must:

(1) have a separate contract to provide primary home care services in each DHS region in which services are to be delivered;

(2) deliver primary home care services through the personal assistance services (PAS) category of licensure;

(3) have the counties in the DHS contract for primary home care services included in the identified licensed service area on file at DHS within personal assistance services category of licensure; and

(4) be authorized by the secretary of state to do business in the State of Texas (if an out-of-state corporation).

(b) A provider agency may request that DHS amend the agency's contract to add counties, if the following conditions exist:

(1) The provider agency has a contract with DHS for each DHS region served; and

(2) The counties to be added to the contract are included in the identified licensed service area on file at DHS within personal assistance services category of licensure.

§47.4903. Provisional Contracts.

(a) A provisional contract is limited to one year. The Texas Department of Human Services (DHS) may extend a provisional contract if:

(1) the formal review, including any reexamination, has not been completed prior to the end of the provisional contract period, or

(2) DHS is unable to successfully transfer all clients by the end of the provisional contract period.

(b) Prior to applying for a DHS contract, the home and community support services agency (HCSSA) must:

(1) hold the license used to qualify for the contract for at least one year;

(2) have completed an on-site health survey; and

(3) be eligible for that license to be renewed.

(c) During the 12 months immediately preceding application for a DHS contract, the HCSSA must have provided attendant or home health services:

(1) to at least ten clients, with at least two of these clients having received on-going services during a 60-day block of time; and

(2) for a total of at least 500 hours.

(d) The services in subsection (c) of this section must have been provided in the region in which the contract application is made or in a county contiguous to that region.

(e) DHS will not enter into a provisional contract until the HCSSA has received a pre-contract orientation from DHS.

(f) DHS will not enter into a provisional contract if a HCSSA is:

(1) under a monitoring agreement, defined as a licensure action, mutually agreed upon by the service provider and DHS, in which the provider agrees to hire a consultant to assist in correcting problems identified in the survey;

(2) has a license revocation action pending with DHS; or

(3) has a Level II administrative penalty pending with DHS.

(g) Any contracts entered into after the effective date of this rule will be provisional contracts, including contracts to existing HCSSAs expanding into a new region.

(h) A HCSSA contracting under a new vendor number as a result of a contract assignment will receive a provisional contract, but is exempt from the requirements in subsections (b),(c), and (d) of this section.

(i) DHS may choose not to contract with a HCSSA if, in the preceding 12 months, the HCSSA had any Level II administrative penalties imposed by departmental order.

(j) DHS may not contract with a HCSSA if, in the preceding 24 months, the HCSSA had any community care program contract involuntarily terminated.

(k) Notwithstanding other department rules regarding formal reviews, for provisional contracts, this subsection prevails.

(1) DHS will formally review provisional contracts at least once during the contract's provisional status.

(2) A HCSSA not in compliance with program-specific requirements after the formal review cannot enter into another Primary Home Care (PHC) contract with DHS for at least 24 months from the end date of the provisional contract. Twenty-four months after the end date of the prior provisional contract, the HCSSA may apply for another provisional contract.

(3) A HCSSA choosing to withdraw from the provisional contract cannot enter into another PHC contract with DHS for at least 12 months from the end date of the provisional contract. Twelve months after the end date of the prior provisional contract, the HCSSA may apply for another provisional contract.

(4) If DHS determines that a HCSSA is not in compliance with one or more program-specific requirements, the provider agency may request a reexamination of the determination.

(A) The provider agency must submit the request in writing, and the appropriate DHS staff must receive it within 10 calendar days of the date of the formal review exit conference.

(B) The provider agency's written request must contain a concise statement of the specific actions or determinations it disputes and any supporting documentation the provider agency deems relevant to the dispute.

(C) The lead DHS staff member coordinates a reexamination of the formal review determination with appropriate DHS staff. DHS staff may request additional information from the provider agency.

(D) Within 30 days of the date DHS receives the request for reexamination or of the date DHS receives additional requested information, the lead staff member must send the provider agency DHS's written decision.

(5) If DHS determines that a HCSSA did not meet the requirements in subsection (c) of this section prior to obtaining a DHS contract, the provisional contract will be involuntarily terminated.

§47.4904. Current Contractors.

(a) Conflict of rules. Notwithstanding other department rules regarding termination, this section prevails.

(b) Voluntary termination of a contract. For a period of at least 12 months after a voluntary termination of a contract, the Texas Department of Human Services (DHS) will not recontract with the home and community support services agency (HCSSA) for Primary Home Care (PHC) services in the region covered by the terminated contract. At the end of the 12-month period, the HCSSA may apply for a provisional contract.

(c) Involuntary termination of a contract.

(1) For a period of at least 24 months after a contract was involuntarily terminated, DHS will not enter into a PHC contract with:

(A) the HCSSA anywhere in the state; or

(B) any HCSSA with a person with a controlling interest, who also had a controlling interest in the HCSSA that was involuntarily terminated.

(2) If a HCSSA contract is involuntarily terminated for failure to deliver community care services for six consecutive months, the HCSSA may not recontract with DHS to provide services in the region covered by its terminated contract for six months after the involuntary termination.

(3) The involuntary termination of a PHC contract in one region will not automatically result in the involuntary termination of PHC contracts held by the same HCSSA in other regions. DHS will review the HCSSA's contracts in other programs or regions to determine if there is cause for further terminations.

(4) If a HCSSA contract is involuntarily terminated, the HCSSA must demonstrate to DHS that the conditions which caused the involuntary termination have been resolved prior to entering into another contract.

(d) Reasons for termination. In addition to the reasons specified in §49.19(b)(3) of this title (relating to Sanctions), DHS may terminate the existing contract of a HCSSA if, in the preceding 12 months, the HCSSA had any Level II administrative penalties imposed by departmental order.

(e) Formal reviews. DHS will conduct a formal review of each HCSSA contract at least once every two years.

§47.4905. Option To Contract for Family Care Services. Primary home care provider agencies may apply to provide family care services as a second service under the primary home care program.

Subchapter E, Support Documents

§47.5902. Reimbursement Methodology for Primary Home Care.

(a) General requirements. For the completion and submittal of cost reports pertaining to providers' fiscal years ending in calendar year 1997 and subsequent years, providers must apply the information in this section. The Texas Department of Human Services (DHS) or its designee applies the general principles of cost determination as specified in §20.101 of this title (relating to Introduction).

(b) Cost reporting. Providers must follow the cost-reporting guidelines as specified in §20.105 of this title (relating to General Reporting and Documentation Requirements, Methods and Procedures).

(1) All contracted providers must submit a cost report unless the number of days between the date the first DHS client received services and the provider's fiscal year end is 30 days or fewer. The provider may be excused from submitting a cost report if circumstances beyond the control of the provider make cost report completion impossible, such as the loss of records due to natural disasters or removal of records from the provider's custody by any governmental entity. Requests to be excused from submitting a cost report must be received at the address specified in the letter mailed with the cost report before the due date of the cost report.

(2) Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determine recommended reimbursement. DHS or its designee excludes from reimbursement determination unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers. The purpose is to ensure that the database reflects costs and other information which are necessary for the provision of services and are consistent with federal and state regulations.

(A) Individual cost reports may not be included in the database used for reimbursement determination if:

(i) there is reasonable doubt as to the accuracy or allowability of a significant part of the information reported; or

(ii) an auditor determines that reported costs are not verifiable.

(B) When material pertinent to proposed reimbursements is made available to the public, the material will include the number of cost reports eliminated from reimbursement determination for the reason stated in subparagraph (A)(i) of this paragraph.

(c) Reimbursement determination. Reimbursement is determined in the following manner.

(1) Cost determination by cost area. Allowable costs are combined into three cost areas, after allocating payroll taxes to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense and after applying employee benefits directly to the corresponding salary line item.

(A) Field supervisors cost area. This includes field supervisor's salaries, wages, benefits, and mileage reimbursement expenses.

(B) Nonpriority attendants cost area. This includes nonpriority attendants' salaries and wages, benefits, and mileage reimbursement expenses. This cost area is calculated as specified in §20.112 of this title (relating to Attendant Compensation Rate Enhancement).

(C) Priority 1 attendants cost area. This includes Priority 1 attendants' salaries and wages, benefits, mileage reimbursement, expenses. This cost area is calculated as specified in §20.112 of this title (relating to Attendant Compensation Rate Enhancement).

(2) Recommended reimbursement by cost area. For the cost areas described in paragraph (1)(A) and (D) of this subsection, the following is calculated:

(A) Projected costs. Each provider's total allowable costs, excluding depreciation and mortgage interest, per unit of service are projected from each provider agency's reporting period to the next ensuing reimbursement period, as described in §20.108 of this title (relating to Determination of Inflation Indices) to calculate the projected expenses. Reimbursement may be adjusted where new legislation, regulations, or economic factors affect costs as specified in §20.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs).

(B) Projected cost per unit of service. To determine the projected cost per unit of service for each provider agency, the total projected allowable costs for each cost area are divided by total units of service, including nonpriority services and Priority 1 services, in order to calculate the projected cost per unit of service for each cost area.

(C) Projected cost arrays. All provider agencies' projected allowable costs per unit of service are rank ordered from low to high, along with each provider agency's corresponding units of service for each cost area.

(D) Recommended reimbursement for each cost area component. The hours of service used to calculate each cost area component for each provider agency are summed until the median hour of service is reached. The corresponding projected expense is the weighted median cost component. The cost component for each cost area is multiplied by 1.044 to calculate the recommended reimbursement for each cost area component.

(3) Total recommended reimbursement.

(A) For nonpriority clients. The recommended reimbursement is determined by summing the recommended reimbursement described in paragraph (2) of this subsection and the cost area component from paragraph (1)(B) of this subsection.

(B) For Priority 1 clients. The recommended reimbursement is determined by summing the recommended reimbursement described in paragraph (2) of this subsection and the cost area component from paragraph (1)(C) of this subsection.

(d) Reimbursement determination authority. The reimbursement determination authority is specified in §20.101 of this title (relating to Introduction).

(e) Desk reviews and field audits of cost reports. Desk reviews or field audits are performed on cost reports for all contracted providers. The frequency and nature of the field audits are determined by DHS or its designee to ensure the fiscal integrity of the program. Desk reviews and field audits will be conducted in accordance with §20.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports), and providers will be notified of the results of a desk review or an audit in accordance with §20.107 of this title (relating to Notification of Exclusions and Adjustments). Providers may request an informal review and, if necessary, an administrative hearing to dispute an action taken under §20.110 of this title (relating to Informal Reviews and Formal Appeals).

(f) Factors affecting allowable costs. Providers must follow the guidelines in determining whether a cost is allowable or unallowable as specified in §20.102 of this title (relating to General Principles of Allowable and Unallowable Costs) and §20.103 of this title (relating to Specifications for Allowable and Unallowable Costs).

(g) Reporting revenues. Revenues must be reported on the cost report in accordance with §20.104 of this title (relating to Revenues).

Subchapter F, Sanctions

§47.6902. Sanctions. A sanction may be imposed even if none of the administrative actions listed in §79.2105 of this title (relating to Grounds for Fraud Referral and Administrative Sanction) have been imposed.

ATTENDANT ORIENTATION/SUPERVISORY VISIT

September 2003

PURPOSE

- To provide a standardized record of attendant orientation, including verbal orientation to a special attendant.
- To provide an individualized service plan signed by the client or family.
- To provide a standardized record of supervisory visits.
- To notify the DHS caseworker between reassessments that a change in the client's authorized hours is indicated.
- To notify the DHS caseworker that services are no longer needed.

PROCEDURE

When to Prepare

The supervisor completes Form 3040 when orienting a new attendant, providing verbal or written instructions to a special attendant, conducting a supervisory visit, or when a change in the client's authorized hours is indicated.

Number of Copies

Prepare Form 3040 in quadruplicate.

Transmittal

1. File the original in the client's record.
2. Give one copy to the attendant after completing orientation. (For a special attendant, document whether the instruction is verbal or written, and file the original in the client's record.) If written instructions are provided, the special attendant keeps a copy.
3. Give one copy to the client.
4. Send two copies to the DHS caseworker when a need for a change in hours or termination of services is indicated. Copies must be legible.

Form Retention

Keep this form for five years from the date the last services were provided to the client.

Supply Source

This form must be photocopied from the *Community Care Provider Forms Manual*.

DETAILED INSTRUCTIONS

Attendant Orientation: Complete pages 1 and 2.

Combined Attendant Orientation/Supervisory Visit: Complete pages 1 and 2.

Supervisory Visit: Complete Page 1 only.

PAGE 1 — Instructions

Client Name — Enter the client's name as it appears on Form 2101.

Client Number — Enter the client's number as it appears on Form 2101.

Date — Enter the date (month, day, year) of the orientation and/or supervisory visit.

BP, Pulse, Respiration — This item is not applicable. Either mark as not applicable or leave blank.

Frequency of Sup. Visits — The supervisor determines the frequency of supervisory visits and enters the frequency (e.g., every 60 days, or every 30 days) at the initial visit as documentation of the plan of supervision. If the provider agency uses a different form to document the client's individualized service plan, the supervisor enters "N/A."

Level of Supervision — This item is not applicable. Either mark as not applicable or leave blank.

Attendant Name — Enter the name of the attendant oriented and/or evaluated at the supervisory visit (beginning on line A). Check the appropriate box:

AO — Attendant Orientation

SV — Supervisory Visit

SA — Special Attendant

Check "AO" and "SV" if a combined attendant orientation/supervisory visit is being conducted.

If the attendant orientation and/or supervisory visit was conducted with more than one attendant, enter the additional names beginning with line B. Ensure all information pertaining to each attendant is entered in the appropriate spaces throughout the form.

Special Attendant. If the attendant is a special attendant, enter the name of the attendant assigned to the client. Check the SA (Special Attendant) box in addition to the other boxes that indicate the purpose of the visit.

1. Symptoms and Limitations — Complete this item at every attendant orientation/supervisory visit, including verbal orientation to a special attendant. Ask the client to describe the symptoms and functional limitations that cause a need for help with personal care tasks. Be specific about any changes that have occurred since the last visit. (Client's assessment should be limited to the space for Item 1.)

Verbal Orientation. The intent of completing this item during a verbal orientation is to provide the attendant with information about the client before providing the service. Item 1 must include symptoms and limitations of the client. Resources that can be used to complete this item include the nursing assessment, physician's orders, etc.

2.Tasks/Service Plan — Complete this item at each attendant orientation/supervisory visit.

Item 2A. Tasks/Service Plan — For attendant orientation/supervisory visits, check the tasks the attendant(s) named on Form 3040 is to perform.

Frequency. Indicate task frequency as follows:

W — weekly

D — daily (Indicate how often during the day the task is to be provided to the client. **Example:** 1D means once a day, 2D means twice a day.)

PRN — as needed.

Item 2A. Performance — During the supervisory visit, observe or ask the client or family members how the assigned tasks are performed by each attendant. For each assigned task and attendant, indicate satisfactory performance with an "S" or unsatisfactory performance with a "U." Complete the performance box according to the list following if a new attendant is being oriented, if the client does not have an attendant, if this is a combined orientation/supervisory visit, or if a task is not being performed by the attendant named on the form:

- a. Orientation visit — write AO. (Do not use "not applicable.")
- b. Supervisory visit where there is no attendant currently assigned to the client — write "not applicable."
- c. Combined attendant orientation/supervisory visit — For attendant orientation write AO. (Do not use "not applicable.") For supervisory visit, rate attendant as appropriate.
- d. Supervisory visit where there is an attendant assigned to the client — rate attendant as appropriate.

- e. Supervisory visit where a task is not being performed by the attendant (for single attendants) named on Form 3040 — write “not applicable.”

For multiple attendants the performance box for a particular attendant may be left blank or “N/A” may be entered if the tasks are being performed by at least one attendant.

The following terms may be used to denote “not applicable”: n/a, N/A, not appropriate, not app., etc.

Task(s) Add/Delete — During the supervisory visit, determine if any tasks need to be added or deleted from the client’s service plan. Enter appropriate response in Item 3B.

Item 2B. Number of Hours — Enter the total number of hours that the client is authorized to receive on Form 2101. The authorized hours may serve as the attendant service schedule if the client agrees to this in writing. If the client does not agree, enter the service schedule the client does agree to on Page 2.

3. Continued Need for PHC —

Item 3A — Ask the client if he or she continues to need primary home care (PHC), family care (FC), or community attendant (CA) services. Check “Yes” or “No” to indicate if the client continues to need PHC, FC, or CA services. If “No” is checked, Item 3B must be checked “Yes.”

Item 3B — Check “Yes” or “No” to indicate if change in hours or service termination is needed. If “Yes” is checked, specify needed changes. If “No” is checked, no other entries are needed.

When Item 3B is checked “Yes,” you must complete the written portion of this item by specifying the hours to be added and explain why the change is needed. If service termination is needed, use this space to explain why.

Enter the name of the caseworker and the date Form 3040 is mailed to the caseworker. Mail the form to the caseworker within seven days after the attendant orientation/supervisory visit. It is not necessary to complete the caseworker information or mail the form to the caseworker if Item 3B is checked “No.”

Caseworker-initiated plan changes. If a home visit is made in response to the caseworker’s plan change request, complete the items on Form 3040, including Item 3, that are necessary to assess the need for the increase in hours.

Provider agency-initiated plan changes. Complete page one of Form 3040, including Item 3, to indicate specific changes to the service plan that require change in hours as well as the reasons for the change and submit to the caseworker.

4. Client's Satisfaction with Services — During the supervisory visit, ask the client if he or she is satisfied with the services provided by the attendant(s). Check “Yes” or “No.”

For multiple attendants, if the client is not satisfied with services provided by one or more attendants, identify attendant, problem(s), and corrective action on Item 6.

If the client does not currently have an attendant, or if the client is disoriented, confused, or cannot respond, check “N/A.” If this is a combined supervisory/orientation visit, check “Yes” or “No.”

5. Client's Satisfaction with Attendant's Schedule — During the supervisory visit, ask the client to describe the attendant's schedule. After the client has described the attendant's schedule, determine if each attendant is following the schedule entered on Form 3054. Check “Yes” or “No”.

For multiple attendants, if the client is not satisfied with services provided by one or more attendants, identify attendant, problem(s), and corrective action on Item 6.

If the client does not currently have an attendant, or if the client is disoriented, confused, or cannot respond, check “N/A.” If this is a combined supervisory/orientation visit, check “Yes” or “No.”

6. Service Delivery Problems — Complete this item at every supervisory visit.

Service delivery problems, unsatisfactory performance by the attendant, or both must be addressed in this item. Record corrective actions and the date the actions were taken.

Example: The attendant may not be performing the transfer task correctly, causing the client to complain about pain or discomfort. Corrective action: “Trained attendant in proper transfer techniques through demonstration on (specific date).” **Note:** Corrective action should occur as soon as possible after a problem is identified. (Even though Items 2A, 4, and 5 are marked “Satisfactory” or “Yes,” Item 6 may be used to document training of attendants.) Item 6 must not be left blank; entries must relate to the attendant and not to the client. (Additional comments about the client are acceptable.) If there are no problems, enter “None,” “N/A,” “No comment,” compliments for the attendant, etc.

Signatures

Client. If the form is used as the client's individualized service plan, the client signs page 1 to indicate he or she agrees with the individualized service plan. If the client is unable to sign, a family member may sign for the client. If the provider agency uses a different form to document the client's individualized service plan, the supervisor enters “N/A.”

Supervisory. The supervisor who conducted the supervisory visit must complete and sign page 1.

Attendant. The attendant signs the form if present.

Combined Attendant Orientation/Supervisory Visit. The supervisor who conducted the attendant orientation/supervisory visit must complete and sign pages 1 and 2 of Form 3040.

Agency Name/Vendor No. — Optional — Enter the provider agency name and vendor number.

PAGE 2 — Instructions

Client Name — Enter the client's name as it appears on Form 2101.

Client Number — Enter the client's number as it appears on Form 2101.

7. Orientation — Complete this item when orienting the attendant(s).

All topics (7-1 through 7-7) must be checked and blanks (7-3 and 7-4) must be completed. Topic 7-3 must include the name and telephone number of the supervisor the attendant is to contact. Describe the situations specific to the client or other specific changes in the client's condition the attendant is to report in the section marked "Other."

Attendant Orientation Signatures: Supervisor/Attendant(s) —

Attendant Orientation. The supervisor who conducted the attendant orientation must complete pages 1 and 2 and sign page 2.

Each attendant oriented must certify that orientation was conducted in the client's home on Items 2 and 7. Certification for the special attendant is not required.

Combined Attendant Orientation/Supervisory Visit. The supervisor who conducted the attendant orientation/supervisory visit must complete and sign both pages 1 and 2 of Form 3040.

Attendant Schedule Optional — Entering the attendant's schedule is optional.

FORM 3050-A
Instructions

**PRIMARY HOME CARE HEALTH ASSESSMENT/
INDIVIDUAL SERVICE PLAN**

September 2003

PURPOSE

- To provide a standardized record of the client assessment and service plan.
- To provide the DHS regional nurse with information required to request prior approval for primary home care.

When to Prepare

The provider agency supervisor completes Form 3050-A when he visits a client referred for primary home care (PHC), family care (FC), or community attendant (CA) services. For PHC and CA services, after the supervisor completes Form 3050-A, he sends a copy to the client's practitioner with Form 3052, Primary Home Care Practitioner's Statement of Medical Need.

Number of Copies

Prepare Form 3050-A in triplicate.

Transmittal

One copy of Form 3050-A may be retained by the practitioner determining medical need. Keep the original in the client's record. Send one copy to the DHS regional nurse when requesting prior approval. Give one copy to the client.

Form Retention

Keep this form in the client's health record for five years after services are terminated by the provider agency.

Supply Source

This form must be photocopied from the *Community Care Provider Forms Manual*.

DETAILED INSTRUCTIONS

Client Identification

Name — Enter the client's name as it appears on Form 2101.

Client No. — Enter the client's number as it appears on Form 2101.

Telephone No. — Enter the client's telephone no. or indicate "none."

Living Conditions, Safety or Health Hazards — Specify home conditions that affect service delivery, such as "no running water," "water must be heated on stove for bathing," "no bathtub or shower," or "no stove or refrigerator." Describe safety or health hazards such as "broken stairs," "open gas flame heater," or "no heat in the home."

Assistive Devices or Medical Equipment — Describe assistive devices or medical equipment currently used by the client; for example, "Client uses a bedside commode at night." If none, indicate "none."

Hospitalization — If none within the last three months, indicate "none."

Other Services Client Receives — If services appear to duplicate PHC, FC or CA services, note in the comments section on page 2 the date of contact with the DHS caseworker and result of the discussion.

Client Information — 'Temp.', 'Pulse', 'Respiration', 'BP', and 'Level of Supv.' are not applicable. Either mark as not applicable or leave blank. Enter the frequency of supervisory visits.

Mobility Level — "With help" means that the client needs help from another person.

Elimination

Bowel This section is not applicable. Either mark as not applicable or leave blank.

Bladder This section is not applicable. Either mark as not applicable or leave blank.

Health Assessment

Use this section to document the social assessment completed by the supervisor. Use the client's self report to document his or her condition and need for services. Document for the client's self report the need for at least one personal care task. For example, "The client is unable to bathe due to stiff joints."

Service Plan — Indicate frequency as follows:

PRN = as needed

W = weekly

D = Daily (specify how often during the day. For example, 1D means once a day, 2D means twice a day.)

If the supervisor disagrees with the service plan designated on Form 2101, he contacts the caseworker to discuss the differences. The date of contact with the caseworker and result is noted in the comment section on page 2.

Attendant Service Schedule — Indicate the attendant service schedule. The service schedule may be the total authorized hours per week if the client agrees to this in writing.

Name of Attendant(s) — This item is not applicable. Either mark as not applicable or leave blank.

RN Certification — The supervisor who completes the assessment signs and dates the form. The supervisor does not have to be a registered nurse.

Client Signature — The client or responsible party signs here.

FORM 3070
Instructions

**DAY ACTIVITY AND HEALTH SERVICES NOTIFICATION OF CRITICAL
OMISSIONS**

September 2003

PURPOSE

To notify day activity and health services (DAHS) facilities about critical omissions or errors in documentation required for prior approval.

PROCEDURE

When to Prepare

The DHS regional nurse completes Form 3070 when the documentation submitted by the facility for prior approval contains critical omissions or errors that must be corrected before prior approval.

Number of Copies

Prepare Form 3070 in duplicate.

Transmittal and Form Retention

The original is sent to the facility when the prior approval packet is returned for correction. The regional nurse keeps a copy.

DETAILED INSTRUCTIONS

Check each critical error or omission that applies. Enter the due date as 14 days from the date Form 3070 is expected to be mailed to the provider agency. (Count the first day after the mail date as day one.)

In the space under each item or in the additional explanation section, provide details or additional information about the items checked.

Day Activity and Health Services

NOTIFICATION OF CRITICAL OMISSIONS

Client Name (Last, First, Middle)	Client No.
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The documentation submitted by your agency for prior approval of this client has the following omissions/errors:

FORM 3050-A

- ☐ Form 3050-A is missing.
- ☐ Licensed nurse did not: ☐ Sign form. ☐ Date form. ☐ Designate RN/LVN credential following signature
- ☐ Documentation on Form 3050 does not support the medical eligibility criteria.
- ☐ Items A, B in Sections II and III are not completed or are completed incorrectly and medical need cannot be determined.

FORM 3055

- ☐ Form 3055 is missing.
- ☐ MD or DO credential of the physician who signed the form is missing.
- ☐ License number of the physician or osteopath (DO) who signed the form is missing.
- ☐ Physician who signed the order is excluded from participation in Medicare or Medicaid.
- ☐ Physician's signature is missing.
- ☐ Physician's signature date is missing or illegible and the provider agency's stamp-in date is missing.
- ☐ Facility stamp-in date used in lieu of the physician's signature date does not include the name, abbreviated name or initials of the provider agency.

Please make the necessary corrections and resubmit documentation. The corrected documentation must be postmarked or date-stamped by the department by

Due Date

Additional Explanation:

--

<div>Signature—Regional Nurse</div>	<div>Date</div>	<table><tr><td>Telephone No.</td></tr></table>	Telephone No.
Telephone No.			

FORM 3070-A
Instructions

PRIMARY HOME CARE NOTIFICATION OF CRITICAL OMISSIONS

September 2003

PURPOSE

To notify provider agencies about critical omissions or errors in documentation required for prior approval of primary home care and community attendant services.

PROCEDURE

When To Prepare

The DHS regional nurse completes Form 3070-A when the documentation submitted by the provider agency for prior approval contains critical omissions or errors that must be corrected before prior approval is granted.

Number of Copies

Prepare an original Form 3070-A and one copy.

Transmittal and Form Retention

The regional nurse sends the original to the provider agency when the prior approval packet is returned for correction. The regional nurse keeps a copy of Form 3070-A in the client file.

DETAILED INSTRUCTIONS

Client Name (Last, First, Middle) — Enter the client's full name as it appears on Form 2101.

Client No. — Enter the client number as it appears on Form 2101.

Provider Agency Name — Enter the complete name of the provider agency requesting the physician's order.

Vendor No. — Enter the provider agency's vendor number as it appears on Form 2101.

Form 3050-A and Form 3052 — Check each critical error or omission that applies to Form 3050-A and/or Form 3052. There may be more than one critical omission in the prior approval request packet.

Due Date — The due date for return of the corrections to the critical omissions is 14 days from the date Form 3070-A is mailed to the provider agency. (Count the first day after the mail date as day one.)

Additional Explanation — Use this space to provide details or additional information about the items checked.

Signature – Regional Nurse — The regional nurse signs his or her name, including credentials.

Date — The regional nurse enters the date he or she completes Form 3070-A.

Telephone Number — The regional nurse enters his or her telephone number, including area code.

**PRIMARY HOME CARE
NOTIFICATION OF CRITICAL OMISSIONS**

Client Name (Last, First, Middle)	Client No.
Provider Agency Name	Vendor No.

The documentation submitted by your agency for prior approval of this client has the following omissions/errors:

FORM 3050-A

- ☐ Form 3050-A is missing
- ☐ Form 3050-A is incomplete
 - ☐ The supervisor's ☐ signature or ☐ date is missing
 - ☐ Documentation that the person needs at least one specific task is missing
 - ☐ Documentation of the total weekly hours the person is authorized is missing
 - ☐ Documentation of the service schedule is missing (the service schedule may be the weekly authorized hours)

FORM 3052

- ☐ Form 3052 is missing
- ☐ Form 3052 is incomplete
 - ☐ The practitioner did not fully complete the form
 - ☐ The form does not contain the practitioner's
 - ☐ mark indicating medical need
 - ☐ signature
 - ☐ credential
 - ☐ license number
 - ☐ legible signature date, and the provider agency failed to date stamp the form (The date stamp must include the provider agency's name, abbreviated name, or initials)
 - ☐ The practitioner is excluded from participation in ☐ Medicare or ☐ Medicaid

Please make the necessary corrections and resubmit documentation. The corrected documentation must be faxed, postmarked or date-stamped as received by DHS by. .

Due Date

Additional explanation: _____

Signature—Regional Nurse Date

Telephone No.

FORM 3052
Instructions

PRIMARY HOME CARE PRACTITIONER'S STATEMENT OF MEDICAL NEED

September 2003

PURPOSE

To be used by Primary Home Care Program provider agencies to request a statement of medical need from the client's practitioner.

When to Prepare

Form 3052 is completed for initial referrals for primary home care (PHC) and community attendant (CA) services, and for referrals for clients whose initial medical need for services was temporary.

Number of Copies

Prepare an original Form 3052 and a copy.

Transmittal

The provider agency completes Part I of Form 3052 and sends the original to the client's practitioner. The provider agency may send Form 3052 by mail or by facsimile, or hand-deliver Form 3052 to the practitioner. The provider agency must attach a copy of Form 2076, Authorization to Release Medical Information, signed by the client to Form 3052 sent to the practitioner.

The client's practitioner completes Part II of Form 3052 to attest to the client's need for services based on a medical diagnosis.

The practitioner returns Form 3052 to the provider agency and keeps a copy for his files.

The provider agency keeps the original Form 3052 and sends a copy of Form 3052 with Forms 3050-A and 2101 to the DHS regional nurse.

Form Retention

The provider agency must keep Form 3052 in the client's file for five years after creation.

Supply Source

This form must be photocopied from the *Community Care Provider Forms Manual*.

DETAILED INSTRUCTIONS

PART I, Client Information

The provider agency must complete PART I.

Client Name — Enter the client's full name as it appears on Form 2101.

Client No. — Enter the client number as it appears on Form 2101.

Client Address — Enter the client's home address.

Provider Agency Name — Enter the complete name of the provider agency requesting the physician's order.

Provider Agency Supervisor — Enter the complete name of the provider agency supervisor assigned to the client.

Telephone No. — Enter the supervisor's complete office telephone number, including the area code.

Provider Agency Address — Enter the provider agency's address.

PART II, Diagnosis(es)

The client's practitioner must complete PART II.

Medical Diagnosis — The practitioner lists the primary diagnosis that causes the client to need PHC services first. The practitioner may list other applicable diagnosis(es). The provider agency must ensure the practitioner completes at least the primary diagnosis.

PART II, Practitioner's Statement and Certification

The client's practitioner must complete PART III, with the exception of the item "Date of Verbal Statement (if app.)". The provider agency supervisor may fill in the date he or she obtained a verbal statement of medical need from the practitioner.

Statement of Medical Need — Check the appropriate box indicating whether or not the client has a need for PHC services based on a medical diagnosis(es).

Status of Medical Need — Check the box that answers the question "Is the medical need temporary".

Estimated End Date of the Client's Medical Need — Enter the month and year the client's medical need for PHC services is estimated to end. This is only applicable if the need for services is expected to last less than one year or is not ongoing.

Comments — The practitioner enters any appropriate comments regarding the client's need for PHC services.

Signature – Practitioner — The practitioner signs his or her name, including credentials. The practitioner is certifying that:

- the client does or does not have a medical need for PHC services;

- the medical need is permanent or temporary. If the medical need is temporary, the practitioner is certifying the estimated end date of medical need; and
- that the practitioner is not a significant owner, partner and/or member of the provider agency.

Today's Date — The practitioner enters the date he or she signs the statement.

Date of Verbal Statement (if app) — The provider agency supervisor enters the date the practitioner gave a verbal statement of medical need, if applicable. If the date is entered incorrectly, the supervisor who made the error must line through the verbal order date, write in the word "error," and sign or initial the date correction.

Practitioner's Name — Enter the first and last name of the practitioner providing the statement of medical need. Check M.D., D.O. (Doctor of Osteopathy), A.P.N. (Advance Practice Nurse), or P.A. (Physician's Assistant) as appropriate.

License Number — Enter the license number of the practitioner providing the statement of medical need.

State — If the practitioner is not licensed in Texas, indicate the state of licensure. If the practitioner is licensed in Texas, no entry is needed.

Practitioner's Address — Enter the practitioner's complete address, including ZIP code.

Telephone No. (inc. A/C) — Enter the practitioner's office telephone number, including area code.

IN-KIND MATCH CERTIFICATION

Provider: _____

In-kind Contribution(s): _____

For any item identified below, you must provide support documentation.

ITEM	DATE OF RECEIPT	VALUATION

Note: All contributions must meet the requirements of IRS Publication 561 <http://www.irs.gov/pub/irs-pdf/p561.pdf>

Examples of Documentation Include:

- Rent:
1. Letter of Agreement with Owner
 2. Adequate Valuation of Property on a Current Basis (this should be reviewed at least every two years and if senior center based on property value and center participation)
- Labor:
1. Minimum wage
 2. Documented prevailing wage in the Area. For prevailing wage information visit Texas Workforce Commission's website at <http://www.twc.state.tx.us/lmi/lfs/type/wages/wageshome.html>

All in-kind labor must be required for the service to be provided. If you would not hire someone to do the labor if it were not in-kind then you cannot count it.

- Utilities:
1. Copy of Bill
 2. Agreement of Amount Paid if Partial

Name of Contracted Provider

Printed/Typed Name of Signer

Date

Signature